FORM B10 (Official Form 10) (Rev. 4/98)

United States Bankruptcy Court
61288, Houston TX 77208

SOUTHERN DISTRICT OF TEXAS P.O.Box
(Houston Division)

PROOF OF CLAIM

Name of Debtors

_X_ **Stage Stores, Inc., a Delaware corporation**
____ **Specialty Retailers, Inc., a Texas corporation**
____ **Specialty Retailers, Inc. (NV), a Nevada corporation**

*place an "x" beside the name of the Debtor you are filing a claim against

Case Number

00-35078-H2-11
00-35079-H2-11
00-35080-H2-11

Creditor ID#: 788-62924
United States Bankruptcy Court
Southern District of Texas
FILED

JUL 2 0 2000

Michael N. Milby, Clerk

Name of Creditor (The person or other entity to whom the debtor owes money or property):

USH/SMMPP, LLC

__ **Check box if you are aware that anyone else a filed a proof of claim relating to your claim. Attach copy of statement giving particulars.**

Name and address where notices should be sent:

**********AUTO**MIXED AADC 900
USH/SMMPP, LLC
10860 N Mavinee Dr
Oro Valley AZ 85737-9526

__ **Check box if you have never received any notices from the bankruptcy court in this case**

__ **Check box if the address differs from the address on the envelope sent to you by the court.**

Account or other number by which creditor identifies debtor:
671253O/671253I

Check here if this claim __ replaces __ amends a previously filed claim, dated: _____

1. Basis for Claim
X Goods sold
__ Services performed
__ Money loaned
__ Personal injury/wrongful death
__ Taxes
__ Other_____

__ Retiree benefits as defined in 11 U.S.C. § 1114(a)
__ Wages, salaries, and compensation (Fill out below)
Your SS#: _____ - _____ - _____
Unpaid compensation for services performed
from _____ (date) to _____ (date)

2. Date debt was incurred: 2/28/00

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 57.14
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.
__ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
__ Check this box if your claim is secured by collateral (including a right of setoff).

Brief Description of Collateral:
__ Real Estate __ Motor Vehicle
__ Other All personal and intangible property of Debtor's Estate

Value of Collateral: $ ____

Amount of arrearage and other charges at time case filed included in secured claim, if any $ _____

6. Unsecured Priority Claim.
__ Check this box if you have an unsecured priority claim
Amount entitled to priority $ _____
Specify the priority of the claim:
__ Wages, salaries, or commissions (up to $4,300),* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3)
__ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(4).
__ Up to $1,950* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
__ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).
__ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
__ Other – Specify applicable paragraph of 11 U.S.C. § 507(a-____).
*Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

Space is for Court Use Only

3902

Date 7/18/00

Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any): Denise Starks
Denise Starks Collection Administrator

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

P US HEALTHWORKS - SMMPP
H 10860 MAVINEE DRIVE
A ORO VALLEY, AZ 85737
R (520) 297-3800

TEXAS WORKERS' COMPENSATION COMMISSION
ALTERNATE FORM TWCC-66C (04/92)

STATEMENT FOR PHARMACY SERVICES
**MAIL THIS FORM TO THE CARRIER **

NABP #:4506804 FID #:86-0905804 INVOICE # 032800-10256A

CARRIER'S CLAIM

DATE OF BILLING: 7/10/2000

C KEMPER
A PO BOX 189132
R
R PLANTATION FL 33318-9132

E STAGE STORES
M JACK CHIPPERFIELD, V-P BENEFIT
P PO BOX 35167
R HOUSTON TX 77235

INJURED EMPLOYEE'S NAME AND ADDRESS

DATE OF INJURY: 8/17/98

E AMAYA MARTIN
M 9025 LINDA VISTA
P
E HOUSTON TX 77014

SOCIAL SECURITY #: 627-01-7218

REFERENCE:
ATTN:

PRESCRIBING DOCTOR'S NAME: PUCEK, MARK D.

NDC:00093100601 RX #: 6712530 WHICH REFILL#: 0 QUANTITY: 14

DRUG NAME AND STRENGTH: NAPROXEN 500MG TABLET EC

SERVICE DATE: 2/28/00 DAYS SUPPLY: 7 GENERIC DRUG: Y RX TOTAL: $30.88

DATE PAID __/__/__ AMOUNT PAID _____.___ EXCEPTION CODE ___

TEXAS WORKERS' COMPENSATION COMMISSION
ALTERNATE FORM TWCC-66C (04/92)

STATEMENT FOR PHARMACY SERVICES
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P US HEALTHWORKS - SMMPP
H 10860 MAVINEE DRIVE
A ORO VALLEY, AZ 85737
R (520) 297-3800

NABP #:4506804 FID #:86-0905804

INVOICE # 032800-10257A

DATE OF BILLING: 7/10/2000

CARRIER'S CLAIM

C KEMPER
A
R PO BOX 189132
R PLANTATION FL 33318-9132

E STAGE STORES
M JACK CHIPPERFIELD, V-P BENEFIT
P PO BOX 35167
R HOUSTON TX 77235

INJURED EMPLOYEE'S NAME AND ADDRESS

E AMAYA MARTIN
M 9025 LINDA VISTA
P
E HOUSTON .TX. 77014

DATE OF INJURY: 8/17/98

SOCIAL SECURITY #: 627-01-7218

REFERENCE:
ATTN:

PRESCRIBING DOCTOR'S NAME: PUCEK, MARK D.

NDC:00086006210 RX #: 6712531 WHICH REFILL#: 0 QUANTITY: 30

DRUG NAME AND STRENGTH: SKELAXIN 400MG TABLET

SERVICE DATE: 2/28/00 DAYS SUPPLY: 5 GENERIC DRUG: N RX TOTAL: $26.26

DATE PAID __/__/__ AMOUNT PAID _____.___ EXCEPTION CODE ___